STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155635	A. BUILDING 00 B. WING	05/27/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRACE VILLAGE HEALTH CARE FACILITY	337 GRACE VILLAGE DRIVE WINONA LAKE, IN46590

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
R0000	This visit was for the Investigation of Complaint IN00090434. Complaint IN00090434- Substantiated, State residential findings related to the allegation are cited at R0243. Survey dates: 5/26-27/11 Facility number: 000501 Provider number: 155635 AIM number: 100266260 Survey team: Ellen Ruppel, RN TC Carol Miller, RN Census bed type: SNF: 9 SNF/NF: 66 Residential: 52 Total: 127 Census payor type: Medicare: 5 Medicaid: 35 Other: 87 TOTAL: 127 Residential sample: 3 This state residential finding is cited in	R0000	Submission and implementation of this plan of correction shall not constitute an admission by Grace Village Health Care to any allegations of deficiency as stated in the "Summary Statement of Deficiencies" or an agreement with any conclusions therein. Rather, this plan of correction is submitted in accordance with State and Federal requirements.Grace Village administration requests that a desk review be used to confirm compliance.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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	accordance with 410 IAC 16.2-5. Quality review completed 5-31-11 Cathy Emswiller RN			
R0243	(3) The individual administering the medication shall document the administration in the individual ' s medication and treatment records that indicate the: (A) time; (B) name of medication or treatment; (C) dosage (if applicable); and (D) name or initials of the person administering the drug or treatment. Based on observation, interviews and record review, the facility failed to ensure 1 of 3 Qualified Medication Aides (QMA) followed the facility procedure for initialing the Medication Administration Record (MAR) after giving medications to residents. (QMA #1) (Resident B) Findings include: During the orientation tour, on 5/26/11 at 9:30 a.m., while accompanied by Social Worker #1, QMA #1 was observed at the end of the hallway giving medications to a resident at the end of the hall. Review of the clinical record and MAR (Medication Administration Record) for Resident B, on 5/26/11 at 10:30 a.m.,	R0243	I. What corrective actions will be accomplished for those residents found to have been affected by the deficient practice?None of the nine residents referenced in the summary statement of deficiencies were found to have been adversely affected. All medications administered that morning have been documented and confirmed to have been given as ordered.II. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken.All twenty-six other residents in Assisted Living 3 had the potential to be affected by the deficient practice of QMA #1. QMA #1 completed the rest of the medication pass utilizing correct documentation and no other	06/26/2011

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	indicated none of the medications scheduled for 9:00 a.m., had been initialed as given. The medications included amiodarone (antiarrhythmia heart medication), Bumex (diuretic), aspirin, hydrocodone/APAP (pain medication), isosorbide (heart medication), loratadine (allergy medication), Plavix (an antiplatelet medication), vitamin B-12, Miralax (a stool softener), and Glucotrol (diabetic medication). QMA #1 was queried, at 10:50 a.m., on 5/26/11, about Resident B's morning medications not being initialed as given. The Director of Nursing (DoN) was present. QMA #1 indicated she had given the medications, but had not signed for them immediately after having administered them. She indicated she had given 8 additional residents their morning medications without signing the MAR as she administered the medications. The facility 2005 policy for medication administration was provided by the DoN, on 5/26/11. The policy indicated "Always chart appropriately after the resident takes the medication or chart that the resident refused..." During an interview with the DoN, on 5/26/11 at 11:00 a.m., she indicated		residents were found to have been affected. QMA #1 was counseled and disciplined.III. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?Facility policy has been revised to state more specifically when documentation should occur during medication administration. Policy now states that medications will be initialed after completion of medication pass to each resident and before beginning a medication pass with the next resident. (Attachment A) All Assisted Living nurses and QMA's will be in-serviced and tested on the revised policy. (Attachment B) Ongoing computerized medication administration in-servicing has been changed to reflect updated policy.IV. How the corrective actions will be monitored to ensure the deficient practice will not recur.The DON or ADON will observe each Assisted Living nurse and QMA at least three times in the next 30 days during medication passes to ensure that proper procedures are followed. (See audit form attachment C) If no concerns are identified, each nurse and QMA will be observed at least one more time within the next 60 days. If any incorrect medication passes are observed, they will be addressed with the employee immediately and will also be brought to the attention of	

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	nursing staff were instructed to record medications immediately after giving them, and then going to the next resident. The personnel file of QMA #1 was reviewed, on 5/26/11 at 1:30 p.m., and indicated QMA #1 had been employed by the facility since 1996, with signatures on a medication guidelines policy dated 1/22/10. The policy indicated the person signing understood the policy. Additional computerized inservice records, dated 2/12-14/11 regarding medications had been completed by the QMA. This state residential finding relates to Complaint IN00090434.		the Quality Assurance Committee.	